CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155687		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPL	ETED	
		15568/	B. WIN			03/14/2	U11
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-N	MUNCIE			'N-MAR DR E, IN47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0000	This visit was for Complaint IN000	r the Investigation of 087405.	F00	00			
	1 ^	087405- Substantiated, ciencies related to the at F223.					
	Survey date: Mar	rch 14, 2011					
	Facility number: Provider number AIM number:						
	Surveyor: Jeri Cı	urtis, RN					
	Census bed type: SNF/NF: 10 Total: 10	9					
	Census payor typ Medicare: Medicaid: Other: Total:	91 5 109					
	Sample: 3						
	in substantial cor Part 483, Subpart Investigation of 0	enter-Muncie was found mpliance with 42 CFR t B in regard to the Complaint IN00087405.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZMTP11 Facility ID: 000097 If continuation sheet Page 1 of 19

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION	(X3) DATE :	ETED
		155687	B. WIN			03/14/2	011
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
	LIVING CENTER-I		2701 LYN-MAR DR MUNCIE, IN47304				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0223 SS=A	Based on record facility failed to a Registered Nurse the collar bone an not occur for 1 (I residents, among reviewed for abute the collar bone and serviewed for abute Tindings include During the 3 M., entrance Administrate facility had a allegation of abuse during The Administrate third shift ce assistant (CN inappropriate registered nurse)	review and interview, the assure physical abuse, a e placing a hand against rea to prevent rising, did Resident A) of 3 the sample of 3, se. 1. 1. 1. 1. 1. 1. 1. 1. 1.	F02		1. The facility followed tha Abu Policy. The allegation of abuse was immediately reported and steps to ensure the safety of a residents were taken.2. No oth residents were affected. Alert oriented residents and other employees were interviewed a no other allegations of abuse were identified.3. Abuse Policy was reviewed and all staff reserviced on the policy.4. Social Services will interview random alert and oriented residents monthly and at resident counce meetings on going. Results will be reviewed in QA monthly for three months and quarterly thereafter.	e all II ner and II no II no II no II	03/14/2011
	Testaent (A)	, ionowing a lan.					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE S COMPL	ETED
		155687	B. WING			03/14/2011	
	PROVIDER OR SUPPLIER		2	2701 LY	DDRESS, CITY, STATE, ZIP CODE N-MAR DR		
	I LIVING CENTER-I				E, IN47304		(7/5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		strator indicated he					
	believed the	incident was					
	magnified by CNA #1 and	y conflict between					
		strator indicated					
		esigned during the					
	investigation						
	C						
	The Director of Nursing (DoN)						
	, who was present during the						
	entrance con	ference, indicated					
	Resident (A)) was transferred to					
	a behavior u	nit on $3/1/11$,					
	_	other, unrelated,					
	incident. Th	e DoN indicated					
	_	ad decided to take					
	(Resident A)						
		om the behavioral					
	unit.						
	The record o	of Resident (A) was					
		14/11, at 11:50					
		dicated a 1/5/11,					
	ŕ	ith diagnoses					
		ut not limited to,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155687		(X2) MULTIPLE O A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER		STREET 2701	r address, city, state, zip code LYN-MAR DR CIE, IN47304	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
		dementia and a			
	history of a colostomy revision.				
	`) had 1/27/11, care			
	_	ns of behaviors			
		lling and hitting			
	during care.				
	Behavioral is				
		essing for and			
	meeting the physical needs and				
	explaining all procedures				
	before begin	ning care.			
	T1 2/20/11	D			
	The 2/20/11,	-			
		icated at 4:00			
	ĺ	xecutive Director			
	` ′	ed a call from			
		ctical Nurse (LPN			
	, ·	orked the secured			
		1 indicated CNA			
	_	ted RN #1 was			
	1	Resident (A) after			
	'	had pulled out a			
	central intrav				
		ing the allegation,			
	LPN #1 had	done a body			
ļ	l			1	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155687		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPI	LETED	
		155687	B. WI			03/14/2	011
	PROVIDER OR SUPPLIER			2701 LY	DDRESS, CITY, STATE, ZIP CODE N-MAR DR E, IN47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	assessment a	and noted redness					
	to the inner a	arms of (Resident					
	A). LPN #1	indicated there					
	were no abra	asions or skin tears.					
	LPN #1 also	indicated when					
	^	Resident (A) had					
	said she was	not mistreated.					
	RN #1 was s	•					
	immediately and an						
	investigation was initiated.						
	The final det	termination was no					
	intent to har	m. The DoN					
	indicated the	e allegation could					
	not be substa	antiated. No					
	injuries were	e noted to Resident					
	(A).						
	A preventive	e measure was					
	in-servicing	of all staff on					
	abuse prohib	oition.					
	The conclud	ing statement of					
	the report in	dicated, after much					
	consideration	n, RN #1 had					
	decided to re	etire due to age.					
	The DoN's in	nvestigation,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155687		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 03/14/2011	
		100007	B. WING	TADDREGG OFFW GRAPE GIR COR		2011
NAME OF I	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COE LYN-MAR DR	DE.	
GOLDEN	I LIVING CENTER-	MUNCIE		CIE, IN47304		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
	conducted at	t 2:10 P.M.,				
	2/20/11, on site at the facility,					
	was also pro	vided for review				
	on 3/14/11.	The DoN indicated				
	she met with	the family of				
	Resident (A)), who were present				
	at the bedsid	le, and explained				
	the allegatio	n, an employee had				
	been accused	d of being abrupt				
	during the n	ight shift.				
	The DoN in	dicated the family				
	did not notic	e any distraught				
	behavior du	ring their 2/20/11,				
	afternoon vi	sit.				
	The DoN's is	nvestigation				
	included into	erviews with CNAs				
	#1 and #2, L	PN #1, and RN				
	#1, who had	been on duty the				
	night of 2/20	0/11.				
	LPN #1 had	stated she had				
	received the	4:00 A.M.,				
	allegation fr	om CNA #1 that				
	_	bused Resident				
	(A). CNA #1	l had reported				
		<u>.</u>				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155687			(X2) MULTIPLE O A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER		2701	raddress, city, state, zip code LYN-MAR DR CIE, IN47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
	Resident (A)) had been placed				
	in a wheel chair after being					
	found on the	e floor. CNA #1				
	1 ^	orted RN #1 had				
	abused (Resi	, ,				
	forcefully pu	ushing (Resident A)				
	back in the c	chair after				
	(Resident A)	attempted to get				
	up again.					
	LPN #1 indi	cated she had				
	notified the	ED, immediately				
	requested R1	N #1 leave the				
	facility, and	had assessed				
	Resident (A)). LPN #1 indicated				
	there was no	redness nor				
	pattern whic	h would indicate a				
	hand grip or	fingerprint on				
	Resident (A)).				
	The DoN's in	nvestigative				
	interview wi	•				
	indicated (C	NA #1) and RN #1				
	were on brea	ak in the lounge				
		#2 entered twice,				
		rt the intravenous				
				1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155687	B. WING			03/14/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE 'N-MAR DR		
GOLDEN	I LIVING CENTER-I	MUNCIE			E, IN47304		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(IV) pulled out, and a second						
	_	rt she had found					
	 `	on the floor.					
		icated RN #1 was					
		ade a comment					
		e word, stating she					
		lieve this, she was					
	still on her break. CNA#1						
	indicated RN #1 had gone to						
	assess Resident (A).						
	CNA#1 ind	licated she went to					
	the unit in a	few minutes to see					
	if she could	help.					
	CNA#1 ind:	icated she					
	witnessed R	N #1 and CNA #2					
	pulling on th	ne arms of					
	(Resident A)	in an effort to get					
	the resident	off the floor. CNA					
	#1 indicated	she was asked to					
	get a chair.						
	_	icated RN #1 and					
	CNA #2 got	(Resident A) from					
	the floor to t	· ·					
	CNA#1 ind	icated she had					
		N #1 push Resident					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155687	A. BUI B. WIN	LDING IG		03/14/2011	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-I	MUNCIF		1	'N-MAR DR E, IN47304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	·	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	` ′	er (Resident A) had					
	attempted to get out of the						
	chair.	,· ,·					
	The DoN's in	•					
		NA #1 had stated					
	_	iterview she did not					
		#1 had intended					
	harm.						
	The DoN's in	· ·					
	summary inc	dicated the night of					
	2/20/11, CN	A#2 had found the					
	IV out, and l	nad reported to RN					
	#1, who was	on break with					
	CNA#1. CN	IA #2 indicated RN					
	#1 had asses	sed (Resident A)					
	and had retu	ırned to break.					
	CNA #2 indi	icated minutes					
	later, she had	d found Resident					
	(A) on the fl	oor, and had again					
	reported to F	RN #1.					
	_	icated RN #1 had					
	come from the	he break area and					
	had started to	o pull Resident (A)					
	from the floo	•					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION	(X3) DATE S COMPL	
		155687	B. WING			03/14/2	011
NAME OF I	PROVIDER OR SUPPLIER		2	701 LY	DDRESS, CITY, STATE, ZIP CODE N-MAR DR		
GOLDEN	I LIVING CENTER-I	MUNCIE	N	1UNCIE	E, IN47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated sho	e assisted RN #1					
	with getting	(Resident A) up					
	when CNA #	#1 came to the area.					
	CNA #2 ind:	icated CNA #1 was					
	requested to	get a chair. CNA					
	#2 indicated	Resident (A) was					
	placed in th	e chair, then					
	started to lean forward.						
	CNA #2 indicated RN #1 had						
	used her hand and had						
	(Resident A)	back into the					
	chair.						
	CNA #2 ind:	icated the hand of					
	RN #1 was a	at throat level when					
	she pushed (Resident A) down.					
	CNA #2 ind:	icated she and					
	CNA #1 dec	ided to report to					
	LPN #1 who	was on duty on					
	another unit.						
	The DoN's is	nvestigative					
		cluded an interview					
	with RN #1,	who said she had					
	ŕ	ounge and was					
		wice for Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155687	B. WING	,		03/14/2	011
	PROVIDER OR SUPPLIER		27	01 LY	DDRESS, CITY, STATE, ZIP CODE 'N-MAR DR 5, IN47304		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	I	_, 11147 304		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
	(A), once for	r the IV and again					
	when (Resident A) was on the						
	floor.						
	RN #1 indic	ated she and CNA					
	#2 had gotte	n Resident (A)					
	from the floo	or to a geri chair,					
	which CNA	#1 was holding in					
	position.						
	RN #1 indicated after						
	placement in the chair,						
	1 ^	started to get up					
	 `	e (RN #1) placed					
	~	chest level and					
	moved Resid	dent (A) back in					
	the chair.	()					
	RN #1 indic	ated the intent was					
	to get the fee	et elevated and to					
	recline Resid						
		ated she did not					
	intend harm.						
		•					
	 Interviews w	vere conducted					
		h CNAs #1 and #2,					
	and with RN						
		to the DoN's					
	1						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155687		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER		STREET A 2701 LY	ADDRESS, CITY, STATE, ZIP CODE YN-MAR DR E, IN47304	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	investigation	n.			
	telephone at 3/14/11, and beginning of 2/20/11, had CNA #1 indifferent while CNA # floor. CNA #1 indifferent (Residuant to the large out the IV are #1 had gone returned. CNA #2 returned. CNA #2 returned area a few mare reported Residuant (A) Resident (A)	indicated the f the shift on been stressful. icated she and RN ne break room #2 monitored the icated CNA #2 break room to dent A) had pulled			

l l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		155687	A. BUILDING B. WING	Ĵ	03/14/2011		
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-	MUNCIE			N-MAR DR E, IN47304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TA	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
	CNA#1 ind	icated CNA #2 and					
	RN #1 got (1	Resident A) up,					
	while she we	ent for a chair.					
	CNA #2 ind	icated she held the					
	chair while l	RN #1 and CNA #2					
	got Resident	t (A) onto her feet					
	and into the	chair.					
	CNA#1 ind	icated Resident (A)					
	raised to get back up and RN						
	#1 placed he	er hand about the					
	throat and p	ushed (Resident A)					
	back into the	e chair.					
	CNA#1 ind	icated she and					
	CNA #2 disc	cussed the					
	incident, and	decided it should					
	be reported.						
	CNA#1 ind	icated she reported					
	her observat	ion to LPN #1,					
	who was on	duty on another					
	unit.						
	CNA #1 ind	icated the					
	Administrator had responded appropriately. CNA #1 indicated when notified, the						
	Administrate	or had LPN #1					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155687	A. BUII B. WIN		03/14/2011		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	l	\neg
GOLDEN LIVING CENTER-MUNCIE					N-MAR DR F IN47304		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			MUNCIE, IN47304			\dashv
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	_	#1 immediately.					
		icated the ADoN					
	arrived to sta						
		shortly after the					
	allegation w	as reported.					
	CNA #2 was	s interviewed by					
	telephone at	4:00 P.M.,					
	3/14/11, and indicated the night of 2/10/11, Resident (A) had						
	pulled out th	e IV. CNA #2					
	1 ^	e had reported to					
		was on break.					
		icated RN #1 was					
		se she was on break					
	_	eave to assess					
	Resident (A)						
	` ′						
	CNA #2 indicated minutes later she had attended to another						
		when she came					
		m, found Resident					
	(A) on the floor.						
	CNA #2 indi	icated she again					
	reported to	RN #1, who was in					
	the break roo	om. CNA #2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687		ULTIPLE CO LDING	(X3) DATE SURVEY COMPLETED		
				G		03/14/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN LIVING CENTER-MUNCIE				1	/N-MAR DR E, IN47304		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
	indicated RN	N #1 came to the					
	unit. CNA #2	2 indicated she and					
	RN #1 knelt	down beside					
	Resident (A)	and got her up					
	from the floo	or. CNA #2					
	indicated Re	sident (A) was					
	resistive.						
	CNA #2 indi	icated CNA #1 had					
	gone for a cl	nair and held it					
	while she an	d RN #1 stood					
	Resident (A)).					
	CNA #2 indi	icated she and RN					
	#1 placed Re	esident (A) into the					
	chair and att	empted to recline					
	the position.						
	CNA #2 indi	icated Resident (A)					
	started to rai	se back up and RN					
	#1 took her l	hand, placed it					
	against the u	pper chest of					
	Resident (A)	to push her back.					
	CNA #2 indi	icated the hand of					
	RN #1 slid to the neck of Resident (A) as she pushed.						
	CNA #2 indi	icated she had been					
	shocked by t	the action of RN #1					

l i		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/14/2011	
			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER		270	1 LYN-MAR DR			
	I LIVING CENTER-			NCIE, IN47304			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENCE		DATE	
	and she and	CNA #1 had					
	decided to re	eport the incident.					
	CNA #2 ind	icated she did not					
	believe RN	#1 had acted					
	intentionally	, however thought					
	it should nev	ver have happened.					
	CNA #2 ind	icated the					
	Administrate	or had LPN #1					
	immediately	relieve RN #1					
	from duty ar	nd the ADoN came					
	in and starte	d an investigation.					
	RN #1 was i	nterviewed by					
	telephone at	4:15 P.M.,					
	3/14/11, and	indicated the night					
	of 2/20/11, s	the and CNA #2					
	had gotten R	Resident (A) up					
	from the flo	or and had lifted					
	her into the chair.						
	RN #1 indicated she and CNA						
	#2 were in front of the resident						
	and CNA #1 was behind,						
	holding the chair.						
	_	ated (Resident A)					
		ed to get back out					
	1						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155687		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/14/2011			
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN47304					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
	of the chair	and she had placed						
	her hand on	the chest to push						
	her back. RN	N #1 indicated she						
	had not show	ved (Resident A).						
	RN #1 indic	ated her hand was						
	on the collar	bone area of						
	Resident (A) back.) as she pushed her						
	RN #1 indic	ated she had been						
	suspended th	nat night						
	immediately	after the incident.						
	The personnel file of RN #1 was reviewed 3/14/11. A							
	2/20/11, sep	aration action form						
	indicated RN	N#1 had						
	voluntarily r	retired while on						
	suspension. The facility's 7/1/08, revised Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse,							
	Injuries of U	Jnknown Sources						

l i		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		155687	A. BUILI B. WING		03/14/2011		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN	I LIVING CENTER-I	MUNCIE			N-MAR DR E, IN47304		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110		ropriation of		ING			Ditt
		icy was provided					
	$\frac{1}{3/14/11}$, by 1	•					
		of the policy was					
		opriate steps to					
	prevent the o	occurrence of abuse					
	or neglect.						
	The correcti	ve action section					
	indicated the	e facility was to					
	make reasonable efforts to						
	determine th	e cause of the					
	alleged viola	ation and to take					
	corrective ac	ction consistent					
	with the inve	estigation findings					
	and to elimin	nate any ongoing					
	dangers to the	ne resident.					
	The investig	ation section					
	indicated wr	ritten statements					
	were not to be requested. Only factual information was to be documented, no assumptions, speculation, or conclusions,						
	were to be d	ocumented.					
	This federal	tag relates to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: 155687		A. BUILDING	(X3) DATE SURVEY COMPLETED 03/14/2011	
ROVIDER OR SUPPLIER		STREET A		1
		I		
SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
complaint IN 3.1-27(a)(1)	N00087405.			
	DEF CORRECTION ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OR COMPlaint IN	DF CORRECTION IDENTIFICATION NUMBER: 155687 ROVIDER OR SUPPLIER LIVING CENTER-MUNCIE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) complaint IN00087405.	TOF CORRECTION IDENTIFICATION NUMBER: 155687 ROVIDER OR SUPPLIER LIVING CENTER-MUNCIE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Complaint IN00087405.	DEF CORRECTION DENTIFICATION NUMBER: 155687 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN47304 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Complaint IN00087405.